STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. Building B. Wing	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Fort Wayne	7519 Winchester Rd Fort Wayne, IN 46819

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed were free from a significant medication error. This error resulted in a change of condition and hospitalization (Resident K). Findings include: An anonymous complaint, submitted to the Indiana Department of Health, indicated Resident K had been administered a double dose of medication which was alleged to have contributed to his death. On [DATE] at 10:23 A.M., Resident K's record was reviewed. Diagnoses included Schizoaffective disorder, bipolar type, alcohol induced persisting dementia, moderate dementia with psychotic disturbance, generalized anxiety disorder, major depressive disorder, and chronic obstructive pulmonary disease (COPD) with current tobacco use. The resident was prescribed several psychotropic medications to treat his behavior symptoms. His behaviors included verbal fights with staff, verbal aggression with other residents, peer to peer altercations, and physical aggression towards staff. A nurse progress note, dated [DATE] at 2:11 p.m., indicated a call had been placed to the psychiatrist regarding Resident K's continued behaviors. Orders were given for Clozaril 150 mg (milligrams) by mouth-give 2 times per day and start weekly lab draws for complete blood counts. A physician order, dated [DATE], was for Clozaril 100 mg tablet by mouth-give 2 times per day along with Clozaril 50 mg tablet to equal Clozaril 150 mg by mouth, given 2 times per day. A timeline, provided by the Director of Nursing (DON) on [DATE] at 10:26 A.M., indicated: -On [DATE] at 2:29 p.m., Clozaril was delivered to the facility and one time order received to give the medication when it arrived. Clozaril 100 mg tablet and Clozaril 50 mg tablet equaled 150 mg was given by mouth to Resident K. -At 3:30 p.m., a second dose of Clozaril 100 mg tablet and Clozaril 50 mg tablet equaled 150 mg was given by mouth to Resident K. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-At 4:00 p.m., the resident was observed to be lethargic. He was taken to his room and laid down in bed. Staff discovered the resident had erroneously been given 2 doses of Clozaril 150 mg which equaled 300 mg of Clozaril administered within an hour. A call was placed to the psychiatric Nurse Practitioner (NP) to notify of the medication error and resident's current condition. -At 4:17 p.m., the psychiatric NP returned call to the facility and indicated she would contact the Psychiatrist for further orders. -At 4:20 p.m., the psychiatric NP called back the facility with recommendations to monitor the resident's vital signs (blood pressure, pulse, respirations, temperature, and pulse oximetry) every 2 hours for 8 hours, then every 4 hours until the resident was awake. Vital signs on [DATE] were: -4:00 p.m., Blood pressure (BP): ,d+[DATE] (normal-,d+[DATE]); pulse (P): 77 (normal-,d+[DATE]); respirations (R): 18 (normal-,d+[DATE]); temperature (T): 96.4 (normal 98.6); Pulse oximetry (normal >90%): 90% on room air. -6:00 p.m., BP: ,d+[DATE], P: 81, R: 20, T: 96.5, Pulse oximetry: 92% on oxygen. -8:00 p.m., BP: ,d+[DATE], P: 91, R: 20, T: 96, Pulse oximetry: 88% on oxygen. -10:05 p.m., BP: ,d+[DATE], P: 79, R: 18, T: 96, Pulse oximetry: 83% on oxygen. Nurse progress notes indicated the following on [DATE]: -5:12 p.m., the NP and doctor were updated on the resident receiving Clozaril. Staff were monitoring vital signs with no concerns. -9:08 p.m., the resident was sleeping without change in condition. -9:20 p.m., the resident was started on a new medication on this day; his vital signs were monitored closely; he was currently resting in bed with the head of the bed elevated; oxygen in place; would continue to monitor. -10:05 p.m., the resident was resting comfortably in bed with oxygen in place and no apparent distress. There was no adverse reaction to the new medication observed; would continue to monitor. -11:00 p.m., the resident continued to rest comfortably with no adverse reaction or distress noted. -11:15 p.m., the resident was observed with no pulse or respirations. CPR (Cardiopulmonary Resuscitation) initiated and 911 called. Once medics arrived, they continued with CPR and resident taken to the hospital. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A hospital History and Physical and Consultation notes, dated [DATE] at 11:19 a.m., indicated the resident had increased behaviors at his nursing home and had been started on Clozaril. The resident had accidentally received 2 doses in a very short length of time which had occurred yesterday ([DATE]). Yesterday evening, the resident was found unresponsive, around 11:,d+[DATE]:20 p.m., CPR was initiated and EMS called. The resident was asystole (no heartbeat) which required 4 rounds of epinephrine and intubation. While hospitalized he remained unresponsive, on the ventilator with questionable aspiration pneumonia (when food or liquid is breathed into the airways or lungs instead of being swallowed) and cardiac/respiratory arrest of unknown origin. On [DATE] at 1:40 P.M., the Psychiatrist was interviewed. He indicated he had been notified of the medication error and 2 doses of Clozaril 150 mg given within an hour of each other. He indicated there was no antidote to be given and the resident was to have his vital signs, including his oxygen saturation, monitored frequently. He indicated if there had been changes in his vital signs, the only intervention to have done was administer intravenous fluids until the resident's vitals stabilized. On [DATE] at 3:00 P.M., Clozaril information was obtained from the website, drugs.com. The website indicated Clozaril was an antipsychotic medication used to treat schizophrenia in adults after other treatments had failed. Clozaril came with a black box warning the medication could cause severe neutropenia (low white blood cell count), low blood pressure, slow heart rate, dizziness, seizures, inflammation of the heart and death in elderly patients with dementia related psychosis; side effects were dose related; starting dose was 12.5 mg one to two times per day which could be increased ,d+[DATE] mg per day if well tolerated; target dose of ,d+[DATE] mg in divided doses by the end of 2 weeks. Low blood pressure, slow heart rate, and cardiac arrest could occur with Clozaril treatment with the highest risk during the initial titration period, especially with rapid dose escalation. These reactions could occur with the first dose, at doses as low as 12.5 mg, which could be fatal. Overdosage: The most commonly reported signs and symptoms associated with Clozaril overdose were sedation, delirium, coma, fast heart rate, low blood pressure, respiratory failure, aspiration pneumonia, heart arrythmias and seizures. The past non-compliance deficiency began on [DATE] and deficient practice corrected on [DATE] after the facility in-serviced all nurses and QMAs (Qualified Medication Aid) on safe medication administration, including signing out of the MAR immediately after administering a medication. All resident MAR (Medication Administration Record) were reviewed for completion the prior 30 days, resident charts audited for documentation accuracy, medication administration policy and procedures reviewed and medication pass competencies completed on all licensed nursing and QMA staff. The facility is monitoring by completing medication pass observations routinely for 6 months. This tag relates to Complaint IN00437523. 3XXX,d+[DATE](c)(2)